New Client Registration Form

Welcome and thank you for choosing Cheekwood Animal Hospital as your pet's veterinary provider. We are dedicated to maintaining the health of your pet and look forward to many future years together.

Please fill out as much information as you can to the questions listed below. Print and bring with you on your first office visit.

Client Information

Owner's Name (Miss, Ms, Mrs., Mr., Dr.) _____

Co-owner's Name _____

Address (& Apt #) _____

City, State, Zip _____

Phone #: Home _____ Work _____ Cell_____

Co-owner's phone # (if different than above) _____

E-mail address_____

How did you find out about our hospital? (circle one) Phone book, sign, location, website, other

If other, please specify: _____

If someone referred you to our hospital, please tell us so we may thank them _____

Have you or any of your other animals registered with our hospital previously? YES NO

Pet Information

Pet's Name _____

Breed (If known) _____ Color _____

Birth Date (If known) _____ Age _____

Sex (circle one) MALE FEMALE Spayed/Neutered (Fixed) YES NO

Special Identification (Tattoo, Microchip, etc) _____

Date of Last: Rabies Shot_____ Fecal_____ Heartworm Check_____

Canine: Distemper_____ Parvo_____ Canine(Kennel) Cough_____

Feline: Distemper(FVRCP)_____ Leukemia/Aids test_____ Leukemia vacc_____

List any other shots (Corona, Lyme, FIV, etc) received and date given:_____

Is your pet on any medication or supplements? YES NO

If yes, please list the medication or supplement and the dose_____

What food does your pet eat? _____

What type of heartworm and flea/tick preventative do you give your pet?

_____

Does your pet have any allergies or drug reactions? YES NO

If yes, please list the allergies and reactions_____

Are there any current or past medical conditions or surgeries of which we should be aware? YES NO

If yes, please comment on the condition or surgery and indicate if they are current or past_____

Payment Policy (Please read and sign)

I understand payment is expected in full at the time services are rendered, and I assume full financial responsibility for all diagnostic and therapeutic procedures. I agree to make full payment for all services by one of the following methods: cash, check, Visa, MC, Discover, or Care Credit.

Signature_____ Date_____